

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02455

CERTIFICATE OF DEATH

02448

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hospital</u>		d. STREET ADDRESS <u>231 Grant ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> First Middle Last <u>Sachs</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Israel Gansler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>101-22-8761</u>	
17. INFORMANT <u>DOROTHY J. MARKS</u> Address <u>SAME AS 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION-MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO (c) <u>15 YEARS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTENSION</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>64</u> , to <u>FEB 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JAN</u> , 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Krichmar</u>		22b. DATE SIGNED <u>FEB 22 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		22d. ADDRESS <u>7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. HEBRON CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>FLUSHING, L.I. N.Y.</u>
24. FUNERAL DIRECTOR <u>Gedberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	
ADDRESS <u>4217 9th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

02456

02449

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASHINGTON</b>		b. COUNTY <b>DC</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>11 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2712 WISCONSIN AVE. 473</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CHEVY CHASE CONVALESCENT CENTER</b> <b>2015 EAST WEST HIGHWAY</b>				d. STREET ADDRESS <b>2015 EAST WEST HIGHWAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GRACE O. SAVAGE</b>		First Middle Last		4. DATE OF DEATH Month <b>2</b> Day <b>8</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-27-1881</b>		9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LIBRARIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EVERETT O'NEILL</b>				14. MOTHER'S MAIDEN NAME <b>LILLIE ANDERSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>		17. INFORMANT <b>ALFRED E. SAVAGE</b> Address <b>7000 SULKY-LA-ROCKVILLE-MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PARKINSON &amp; CEREBRAL BRAIN SYNDROME.</b> 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>ARTERIOSCLEROSIS.</b> DUE TO (c) <b>DEHYDRATION &amp; ELECTROLYTE IMBALANCE.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Several years.</b> <b>Several years.</b> <b>3 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1966</b> , to <b>February 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>February 8, 1967</b> , and that death occurred at <b>12 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Hugo G. Graziani</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>February 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>HUGO G. GRAZIANI, M.D.</b>				22d. ADDRESS <b>10101 GEORGIA AVENUE, SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2/9/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Washington, D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05419

DEPARTMENT OF AGRICULTURE

05420

Approved: \_\_\_\_\_  
Special Agent in Charge, Bureau of Plant Industry

Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02457						02450					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Maryland</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> <b>Prinnee Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hammond Village, Laurel, Md.</b> d. STREET ADDRESS <b>2906 Gorman Rd.</b> <del>7600 Carroll Ave</del> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>FRED</b> First <b>L.</b> Middle <b>SCHMID</b> Last			4. DATE OF DEATH <b>Feb. 1</b> Month <b>1967</b> Day Year								
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>June 18, 1913</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cost Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NASA, Godard Space</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Toledo, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Fred L. Schmid</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Schmid Krueger (Nee Bartel)</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown No</b>		16. SOCIAL SECURITY NO. <b>334-10-0729</b>		17. INFORMANT <b>Mr. Emmanuel Horn, 1704 Court Sq. Bldg.</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery thrombosis</b> OUE TO (c) <b>Arteriosclerosis obliterans</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchogenic carcinoma</b>						INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>years</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 18</b> , 19 <b>67</b> , to <b>Feb. 1</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb. 1</b> , 19 <b>67</b> , and that death occurred at <b>6:30 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Kenneth Cruze</b>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>KENNETH CRUZE M.D.</b>		22d. ADDRESS <b>831 UNIVERSITY BLVD, EAST SIL.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Dorsey, Maryland</b> <b>SPR. MD.</b>					
24. FUNERAL DIRECTOR <b>Howard County Funeral Home of Harry H. Witzke</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

11

107-3203-77



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02458

CERTIFICATE OF DEATH

02451

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		15-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>2810 Parker Ave., Wheaton</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Irene Virginia Scott</b>				4. DATE OF DEATH Month Day Year <b>February 11 19 67</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/9/85</b>	
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>					
13. FATHER'S NAME <b>Henry Ratcliff</b>				14. MOTHER'S MAIDEN NAME <b>Laura Greenwell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no --</b>		16. SOCIAL SECURITY NO. <b>220-54-0966</b>		17. INFORMANT Address <b>Hospital Records Olney, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage Cerebral</b> DUE TO (b) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>arteriosclerosis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>4 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19, to <b>Feb. 11</b> , 19 <b>67</b> , that (I) (we) just saw the deceased alive on <b>Feb. 11</b> , 19 <b>67</b> , and that death occurred at <b>3:15</b> P.M., from causes and on the date stated above.							
22a. SIGNATURE <b>A.W. Smith</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>A.W. SMITH</b>		22d. ADDRESS <b>13018 GEORGIA AVE Olney, Maryland WHEATON, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. RECEIVED BY REGISTRAR DATE <b>FEB 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

02459

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02452

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rail Road Track back of Hechtengers</u>				d. STREET ADDRESS <u>810 Westmore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J. STANSBURY</u> First Middle Last				4. DATE OF DEATH <u>FEB 26 1967</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18 1915</u>	9. AGE (In years last birthday) yrs. <u>50</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>James Victor Scriber</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Lyles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-5164</u>		17. INFORMANT <u>Philip H. Scriber</u> Address <u>HOLLYWOOD MARYLAND</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>3220 EXPOSURE (FREEZING)</u> DUE TO (b) <u>Acute Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell along R.R. when drunk and fell asleep + froze -</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>JOHN G. BALL M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>2/27/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL M.D.</u>		Address (Street, city, town, or county) <u></u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>HOLLYWOOD - MARYLAND</u>				
24. FUNERAL DIRECTOR <u>John M. Welch - Leonardtown, Md</u>		ADDRESS <u></u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

02123

02123

112.1

7.21222

RECEIVED

DATE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #14 infor. taken from birth cert. 2/14/67 pc

02460

CERTIFICATE OF DEATH

02453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>38 hrs 14m</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>				d. STREET ADDRESS <u>3361 Old Lion Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Setzer</u> Last <u>Setzer</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/67</u>		9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>38</u> Hours <u>14</u> Min.	IF UNDER 24 HRS. Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Setzer</u>				14. MOTHER'S MAIDEN NAME <u>Ollie Louise Pugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Robert Setzer</u>		Address <u>Laurel, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Marked Prematurity</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Respiratory Distress Syndrome</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8</u> , 19 <u>67</u> , to <u>Feb. 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 9</u> , 19 <u>67</u> , and that death occurred at <u>1:30 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>H.B. Berkowitz</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. B. Berkowitz</u>				22d. ADDRESS <u>Laurel, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1331 Rock. Pike</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 14 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02153

STATE OF TEXAS

02153

THIS IS TO CERTIFY THAT THE FOLLOWING IS A TRUE AND CORRECT COPY OF THE  
ORIGINAL AS FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT  
OF THE COUNTY OF DALLAS, TEXAS, ON THE 15TH DAY OF MAY, 1904.  
AT DALLAS, TEXAS, THIS 15TH DAY OF MAY, 1904.  
CLERK OF DISTRICT COURT

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02461

## CERTIFICATE OF DEATH

02454

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN Tb <b>15 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>		d. STREET ADDRESS <b>405 DENHAM ROAD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GERTRUDE W. SHOEBOOTHAM</b>		4. DATE OF DEATH Month Day Year <b>FEB. 18, 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/11/96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>70</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>NEBRASKA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK COOPICH</b>		14. MOTHER'S MAIDEN NAME <b>ADELAIDE STARK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>505-404414</b>	
17. INFORMANT <b>WILDA I. RUSH DAUGHTER</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> DUE TO <b>Cerebral thrombosis</b> (b) <b>Boeck's Sarcoid</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Endarterectomy of innominate artery, surgery on 2/15/67</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/9/67</b> , 19 <b>67</b> , to <b>2/18/67</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>2/18</b> , 19 <b>67</b> , and that death occurred at <b>4:35</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph F. Schannon M.D.</b>		22b. DATE SIGNED <b>2/19/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph F. Schannon, M.D.</b>		22d. ADDRESS <b>8218 Wisconsin Ave. Bethesda</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairbury</b>	23d. LOCATION (City or Town) (County) (State) <b>Fairbury, Nebraska</b>
24. FUNERAL DIRECTOR <b>Lyson Wheeler 1331 Rockville Pike Rockville, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05424

05424



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02462

02455

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10,002 Kinross Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10,002 Kinross Street</u> <span style="float: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wilbert Henry Shoemaker</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>21</u> Year <u>19 67</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED	<b>8. DATE OF BIRTH</b> <u>June 14, 1907</u>	<b>9. AGE</b> (In years last birthday) <u>59</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>D. C. Transit Co.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Henry P. Shoemaker</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Bremmerman</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WWII</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Yes</u>		<b>17. INFORMANT</b> <u>Clarence E. Shoemaker</u> <span style="float: right;">Address <u>5330 Carolina Place, NW Washington, D. C.</u></span>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 203X <span style="float: right;">DUE TO</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="float: right;">(b)</span> <span style="float: right;">DUE TO</span> <span style="float: right;">(c)</span> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u></span>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour e.m. <u>  </u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Belden R. Reap, M.D.</u> <b>EXAMINER'S NAME</b> (Type) <u>Belden Reap</u> <span style="float: right;">DATE SIGNED <u>2/22/1967</u></span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>LI. 502 Grandview Ave. Silver Spring, Md.</u>					
<b>22b. DATE THEREOF</b> <u>Feb 24, 1967</u>		<b>22d. LOCATION</b> (City, town, or country) <u>Washington, D. C.</u>		<b>(State)</b>			
<b>23. FUNERAL DIRECTOR</b> <u>Clark &amp; Wilson</u> <span style="float: right;">Address <u>41502 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.</u></span>							
<b>24e. REC'D BY REGISTRAR</b> <u>FEB 27 1967</u> <span style="float: right;">24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></span>							

03452

MINICA EXAMINER'S CERTIFICATE OF DEATH

03452

03452

*[Faint, mostly illegible text from a form, likely containing personal and medical details.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
02463						02456													
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)													
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY										
Montgomery			Bethesda			Md.			Mont.										
c. LENGTH OF STAY in 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS										
30 days			Suburban			Rockville			11702 Glen Road										
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH													
First Middle Last						Month Day Year													
Esta Florence Sigler						2-24 1967													
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR									
F		W				10/18/01		65 yrs.		Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
H-wife				Home				Maryland											
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME													
Clarence Butts						Vernie Roebuck													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address							
No												Daughter - Mrs. Dantz - Gaithersburg							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Ventricular Tachycardia						8 hours							
4201 DUE TO						Coronary Occlusion						4 weeks							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO (b)													
						DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19																			
21. I certify that (I) (this hospital) attended the deceased from 8-10, 1961, to 2-24, 1967, that (I) (we) last saw the deceased alive on 2-23, 1967, and that death occurred at 12 AM, from the causes and on the date stated above.												22a. SIGNATURE		22b. ADDRESS		22c. PHYSICIAN'S NAME (Type)		22d. DATE SIGNED	
W. G. Hall												Rockville, Md.		W. G. Hall		2/24/67			
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial												2-27-67		Laytonsville		Laytonsville, Mont. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE												ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis H. Barber												Laytonsville, Md.		FEB 28 1967		J. Charles Judge			

05450

05450

Rockville, Md.

W. G. Hall

Laytonville, Mont. Md.

Laytonville

2-27-57

Francis H. Barker Laytonville, Md.

FEB 28 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1  
4  
M  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02466

CERTIFICATE OF DEATH

02457

1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT GOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 154					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>805 LOXFORD TERRACE</u>					
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>SINGER</u> Last <u>SINGER</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/98</u> 68 YRS.	9. AGE (In years last birthday) <u>68</u> YRS.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MUCKSTER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>RUSSIAN</u>	
13. FATHER'S NAME <u>MORDECAI S. SINGER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMO FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CLARA SINGER</u> Address <u>SAME AS 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus</u> 543X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infectious</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Common Diets, Chronic Pyelonephritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/22/67</u> , 19 <u>67</u> , to <u>2/22/67</u> , that (I) (we) last saw the deceased alive on <u>2/22/67</u> , 19 <u>67</u> , and that death occurred at <u>1007A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert Macon</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/22/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert Macon, M.D.</u>		22d. ADDRESS <u>809 Viers Mill Road, Rockville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>HYATTSVILLE MD.</u>	
24. FUNERAL DIRECTOR <u>GOLBEAR FUNERAL HOME</u>		ADDRESS <u>4217 - 9th St. N.W.</u>		25a. REG'D BY REGISTRAR DATE <u>FEB 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

7250

02250



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02465

CERTIFICATE OF DEATH

02458

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>	
c. LENGTH OF STAY IN 1b <b>10 days</b>		13.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>Route #2</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Rebecca</b> Last <b>Sirk</b>		4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-16-95</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levi Ritchie</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ratcliff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Medical Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident &amp; hemiplegia</b> DUE TO (b) <b>ASCVD</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> , to <b>Feb 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-31 1967</b> , and that death occurred at <b>9:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Frederick Moomau</b> M.D.		22b. DATE SIGNED <b>2-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frederick Moomau, M. D.</b>		22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Feb. 3 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>True Gospel</b>	23d. LOCATION (City or Town) (County) (State) <b>Lisbon Howard Md</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 3 1967</b>	
ADDRESS <b>Laytonsville Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Model's Accuracy

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MONTGOMERY STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02466						CERTIFICATE OF DEATH			02459		
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN lb <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>151</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>10019 Reddick Drive</u>					
3. NAME OF DECEASED (Type or print) <u>Dorothy Virginia Smith</u> First Middle Last						4. DATE OF DEATH <u>February 9</u> 19 <u>67</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 19 1917</u>		9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Justice of Peace &amp; Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. County Police</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Glenn E. Feeneq</u>						14. MOTHER'S MAIDEN NAME <u>Amelia Hutchison</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>577-16-4085</u>		17. INFORMANT <u>Donald Smith</u> <u>10019 Reddick Drive Silver Spring, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infection</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Heart Disease; or coronary</u> <u>PM, myocardial</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>3 mo's</u> <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , to <u>9 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8 Feb</u> , 19 <u>67</u> , and that death occurred at <u>5:34 A.M.</u> from causes and on the date stated above.											
22a. SIGNATURE <u>Merton L. White M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>9 Feb 67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Merton L. White</u>						22d. ADDRESS <u>9911 Georgia Ave Silver Spring</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>			
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles J. J.</u>			

4390

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02467

CERTIFICATE OF DEATH

02460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>2101 16th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-80</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Union Trust Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. F. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Winter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-12-8832</u>	
17. INFORMANT <u>Records - Washington Sanitarium &amp; Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis &amp; Buerger's Disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, deep</u> (c) <u>Arteriosclerosis, deep</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat'While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/8/51</u> , 19 <u>67</u> to <u>2/6/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/5/67</u> , 19 <u>67</u> , and that death occurred at <u>7:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. H. W. L. H. O. N.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas. H. W. L. H. O. N.</u>		22d. ADDRESS <u>831 New Blvd E Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>2.9.67</u>	<u>Rock Creek Cemetery</u>	<u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>25b. REGISTRAR'S SIGNATURE</u> <u>Charles Judge</u>	
ADDRESS <u>Home. 300.4th st N E</u>		DATE <u>FEB 7 1967</u>	





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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
02468		CERTIFICATE OF DEATH		02461	
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>13 1/2 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>7308 LYNNBURST ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARIE B SMITH</u>		4. DATE OF DEATH <u>FEBRUARY 20 19 67</u>		Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>SEPARATED</u>	8. DATE OF BIRTH <u>10-23-10</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Earl Booker</u>		14. MOTHER'S MAIDEN NAME <u>Ollie Anthony</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Brother Issac Booker</u> Address <u>4919 7th St. N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 VENTRICULAR FIBRILLATION</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>CORONARY ARTERY DISEASE, SEVERE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 MINS</u> <u>3 YEARS</u> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>19 FEBRUARY 19 67</u> to <u>20 FEBRUARY 19 67</u> , that (I) (we) last saw the deceased alive on <u>20 FEBRUARY 19 67</u> , and that death occurred at <u>2:04</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S Caldwell MD</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL MD</u>		22d. ADDRESS <u>TENNY BLDG ROCKVILLE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Park</u>	
23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Park Md</u>		24. FUNERAL DIRECTOR <u>Latney's Funeral Home 3831 La Grange Rd. Wash DC</u>			
25a. REC'D BY REGISTRAR <u>FEB 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

13450

MAY 10 1966

13450

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
5M 1/65

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FOR STATE  
HEALTH DEPT.

02469

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G386 3/3/67 mh

02462

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>2 hrs.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>			e. STREET ADDRESS <b>17621 Norwood Road</b>		
3. NAME OF DECEASED (Type or print) First <b>Worthington</b> Middle <b>none</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-8-99</b>	9. AGE (In years less birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FBI agent</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Simon O. Smith</b>		
14. MOTHER'S MAIDEN NAME <b>Evelyn Johnson</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		
16. SOCIAL SECURITY NO. <b>215-44-8240</b>			17. INFORMANT <b>Hospital records- Montgomery General</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute Coronary Insufficiency</b> <b>4201</b> DUE TO (b) <b>Coronary Artery Heart Disease</b> DUE TO (c) <b>Coronary Artery Heart Disease</b> CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Belden R. Reap, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Belden R. Reap, M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. DATE SIGNED <b>2/26/1967</b>		Address (Street, city, town, or county) <b>Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park</b>	
23d. LOCATION (City, town or county) <b>Rockville, Md.</b>		(State)			
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

02485

02485

2/26/1967

Feb 24 1967

FEB 24 1967

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02470

CERTIFICATE OF DEATH

02463

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>6123 BROAD BRANCH RD, N.W.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>BROOKE</u> Last <u>STABLER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICAL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C&amp;P Tele. Co.</u>	9. AGE (In years lost birthday) yrs. <u>91</u>
11. BIRTHPLACE (County & State, or foreign country) <u>SAN MONT. Cty., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES P. STABLER</u>		14. MOTHER'S MAIDEN NAME <u>ALICE BROOKE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-0697</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Sarcoma</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-3</u> , 19 <u>67</u> , to <u>2-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>67</u> , and that death occurred at <u>2AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D L Brody</u>		22b. DATE SIGNED <u>2-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D L Brody</u>		22d. ADDRESS <u>809 Veirs Mill Ad Rockville</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>2-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
ADDRESS <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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02471

CERTIFICATE OF DEATH

02464

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Cabmont St</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>L.</u> Last <u>STANG</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>73</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick C Stang</u>		14. MOTHER'S MAIDEN NAME <u>Rozetha Mossburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <u>2/16-10-1094</u>		17. INFORMANT <u>Ethel S. Stang 2020 E</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastasis</u> DUE TO (b) <u>163X</u> DUE TO (c) <u>3mos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema Arteriosclerosis Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/17</u> , 19 <u>67</u> to <u>2/21</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2/20</u> 19 <u>67</u> , and that death occurred at <u>12:40</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick Y. Donn</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK Y. DONN</u>		22d. ADDRESS <u>10400 Connecticut Ave, Kensington, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>2-24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg Mont. Md</u>
24. FUNERAL DIRECTOR <u>Ernest G. Gartner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Gaithersburg, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05484

17450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

02472		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02465	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>15-1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>W 9701 BEXHILL DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY</b> First Middle Last <b>ISABELLA</b> <b>STAUBER</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 11</b> <b>19 67</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <b>KX</b> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>DEC. 2, 1867</b>		9. AGE (In years last birthday) <b>99</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM MARION BRUNER</b>			
14. MOTHER'S MAIDEN NAME <b>ELIZABETH BRYAN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT Address <b>BENJAMIN R. STAUBER, SON, SAME AS #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypoproteinemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Jan 20, 1967</b> to <b>Feb 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb 10, 1967</b> , and that death occurred at <b>7:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Thibadeau</b>		22b. DATE SIGNED <b>FEB. 11, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU, M.D.</b>	
22d. ADDRESS <b>11000 Old Georgetown Rd., Rockville, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PALOUSE CEMETERY</b>	
23d. LOCATION (City or Town) (County) (State) <b>PALOUSE, WASHINGTON</b>		24. FUNERAL DIRECTOR ADDRESS <b>JOSEPH GAWLER'S SONS, INC. WASH., D.C.</b>			
25a. REC'D BY REGISTRAR DATE <b>FEB 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Judge</b>			

02433

02433

MEMORANDUM

MEMORANDUM

MEMORANDUM

TO : DIRECTOR

TO : DIRECTOR

FROM : SAC, NEW YORK

FROM : SAC, NEW YORK

DATE

DATE

DATE

DATE

DEC. 2, 1961

DEC. 2, 1961

AT HOME

AT HOME

AT HOME

RE: [illegible]

RE: [illegible]

RE: [illegible]

DEC. 11, 1961

ROBERT T. [illegible]

1100 Old Georgetown Rd., Washington, D.C.

12/1/61

12/1/61

12/1/61

12/1/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02473

CERTIFICATE OF DEATH

02466

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville,</u> <u>15-1</u> d. STREET ADDRESS <u>16510 Emory Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary Renner Steelman</u>		4. DATE OF DEATH <u>February 23</u> <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-21-07</u>
9. AGE (In years last birthday) <u>59 yrs.</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Mr. John Curry</u>		14. MOTHER'S MAIDEN NAME <u>Helen Twiss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Patient's chart</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant melanoma, metastatic</u> DUE TO (b) <u>Malignant melanoma, right groin</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1909</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>over 10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>  </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20e. (City or town) <u>  </u>		20f. (County) <u>  </u>	
20g. (State) <u>  </u>		20h. (City or town) <u>  </u>	
20i. (County) <u>  </u>		20j. (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Febr 4</u> , 19 <u>67</u> , to <u>Febr. 23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Febr. 22</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u>		22b. DATE SIGNED <u>2-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>831 University Blvd. E. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 27-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Geo. W. Cemetery</u>		23d. LOCATION (City or town) <u>Springfield, Md.</u>	
23e. (County) <u>  </u>		23f. (State) <u>  </u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25. REC'D BY REGISTRAR <u>  </u>	
25a. ADDRESS <u>254 Capitol St. S.W. Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 27 1967</u>			

03450

03450

UNITED STATES OF AMERICA

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

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02474

## CERTIFICATE OF DEATH

03959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Charleston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>114 E Ben Tillman Homes</b>	
3. NAME OF DECEASED (Type or print) <b>Faith Marie Stelly</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Louisiana, Opelousas, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Floyd Joseph Stelly</b>		14. MOTHER'S MAIDEN NAME <b>Betty Jane Fontenot</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Floyd J. Stelly Charleston, S.C.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 25</b> , 19 <b>67</b> , to <b>Feb. 28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb. 28</b> , 19 <b>67</b> , and that death occurred at <b>3:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>A. E. Tompkins</i>		22b. DATE SIGNED <b>March 1, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. E. Tompkins, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/1/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Burial -Transit</b>		23d. LOCATION (City or Town) (County) (State) <b>Port Barre, Louisiana</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>MAR 8 1967</b>	
25c. ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>			

03553

RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
20 M 1/66

02475

CERTIFICATE OF DEATH

02467

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>38 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>4505 Embler Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>Bradley</u> Last <u>Stephenson</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-19</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. Co. Library</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Dc</u>	
13. FATHER'S NAME <u>Louis F. Bradley</u>			14. MOTHER'S MAIDEN NAME <u>Jessie Shipman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-28-5419</u>		17. INFORMANT <u>Douglas R. Stephenson</u> Address <u>Resident - add same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to carcinoma, left breast</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>58</u> , to <u>2-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-2</u> 19 <u>67</u> , and that death occurred at <u>6:12</u> AM, from causes and on the date stated above.					
22a. SIGNATURE <u>Sarah E. Glover</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>			22d. ADDRESS <u>10128 CEDAR LAKE Kensington Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			25a. REC'D BY REGISTRAR DATE <u>FEB 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

05480

CHARTER OF DEATH

05480

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02476

CERTIFICATE OF DEATH

02468

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> <del>REXEMARK</del>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington GARDENS</u>		d. STREET ADDRESS <u>248 PARK Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Ann</u> Last <u>Stephenson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>82</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George E. Foos</u> <del>XXXXXXXXXX</del>		14. MOTHER'S MAIDEN NAME <u>Rebecca Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Laurie Fluharty, daughter</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> DUE TO (b) <u>Carcinoma Pancreas (suspected)</u> DUE TO (c) <u>Carcinoma Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u> <u>4 mo.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-5 1967</u> , to <u>2-20 1967</u> , that (I) (we) last saw the deceased alive on <u>2-20 1967</u> , and that death occurred at <u>7:55 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>P. L. Sengstack MD</u>		22b. DATE SIGNED <u>2-20-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Plains Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Big Rapids, Michigan</u>
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> <u>4308 Suitland Road, Suitland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

3  
MEDICAL CERTIFICATION

03438

CERTIFICATE OF DEATH

03438



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
02477						02469						
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>						d. STREET ADDRESS <u>1801-16th St N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First <u>Hutton</u> Middle <u>Stewart</u> Last			4. DATE OF DEATH <u>Feb</u> Month <u>7</u> Day <u>1967</u> Year			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 27, 1872</u>			9. AGE (In years last birthday) <u>94</u> yrs.			IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pr. nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Archibald Hutton</u>						14. MOTHER'S MAIDEN NAME <u>Ella Mitchell</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Molly Foster, 1806 New Hampshire Ave N.W. DC</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Old heart attack</u> DUE TO (c) <u>Old cerebrovascular accident</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>64</u> , to <u>2/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.												
22a. SIGNATURE <u>Chas H Volchon</u>						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>Chas H Volchon</u>			
22d. ADDRESS <u>831 Conn. Blvd E. Silver Spring</u>						22e. REC'D BY REGISTRAR			22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Myrl Oline</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C. 20003</u>				
24. FUNERAL DIRECTOR <u>Williamly 131-176 St. SE D.C.</u>						25a. REC'D BY REGISTRAR <u>EB 10 1967</u>						

03480

03480

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02478					02470						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					a. STATE <b>Virginia</b> b. COUNTY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fairfax</b>						
c. LENGTH OF STAY IN 1b <b>5 days</b>					d. STREET ADDRESS <b>10110 Cavalry Drive</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First <b>David</b> Middle <b>Spencer</b> Last <b>Stofko</b>		4. DATE OF DEATH		Month <b>February</b> Day <b>2</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 March 1963</b>		9. AGE (in years last birthday) <b>3</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Stephen Stofko</b>					14. MOTHER'S MAIDEN NAME <b>Nancy Price</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, diffuse, bilateral</b>										<b>7 Days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Acute Lymphocytic Leukemia</b>										<b>4 Months</b>	
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>MD</b> (this hospital) attended the deceased from <b>Jan. 28</b> , 19 <b>67</b> , to <b>Feb. 2</b> , 19 <b>67</b> , that <b>X</b> (we) last saw the deceased alive on <b>Feb. 2</b> , 19 <b>67</b> , and that death occurred at <b>7:30 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Joel Rubenstein</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/2/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Joel J. Rubenstein, MD.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/6/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION (City, town or county) (State) <b>Arlington County, Va.</b>			
24. FUNERAL DIRECTOR <b>Everly Funeral Home</b> By <b>Mgr.</b> <b>Fairfax, Va.</b>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02479

02471

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>303 Hilltop Road</u>		d. STREET ADDRESS <u>303 Hilltop Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DEFOREST SAMUEL STONE</u>		4. DATE OF DEATH <u>February 7, 1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Feb. 3, 1899</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>POTTER Co. Penna. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LOREN LeROY STONE</u>		14. MOTHER'S MAIDEN NAME <u>EVALYN SALISBURY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-468638</u>	
17. INFORMANT <u>Glen E. Stone</u> Address <u>303 Hilltop Rd. T.P.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO <u>350X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DEBILITATION-Aspiration</u> DUE TO (c) <u>PARKINSONS DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> to <u>Feb. 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7</u> , 19 <u>67</u> , and that death occurred at <u>6:15</u> p.m. from causes and on the date stated above.			
22a. SIGNATURE <u>T.H. Lundstrom</u>		22b. DATE SIGNED <u>Feb. 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>T.H. LUNDSTROM</u>		22d. ADDRESS <u>7600 Carroll Ave. Takoma Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville. Mont. Co. Md</u>	
24. FUNERAL DIRECTOR <u>Arthur D. Walters</u> ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20001</u>		25. READ BY REGISTRAR <u>FEB 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			

17450

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02480

CERTIFICATE OF DEATH

02472

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
c. LENGTH OF STAY IN 1b <u>26 days</u>		d. STREET ADDRESS <u>9807 Reed Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>E</u> Last <u>Stone</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-90</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Linkins</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mercer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-03-40280</u>	
17. INFORMANT <u>ARTHUR W. STONE UPPER MARLBORO MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism</u> DUE TO (b) <u>Myocardial ischemia</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/67</u> 19 <u>67</u> , to <u>2/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-26-67</u> 19 <u>67</u> , and that death occurred at <u>8 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>S. J. Cosimano Jr</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>S. J. Cosimano Jr</u>		22d. ADDRESS <u>8218 Wisconsin Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/2/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL. CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>	
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO. WASHINGTON</u>		25. REC'D BY REGISTRAR <u>MAR 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05430

RECORD TO BE MAINTAINED

05430

1. NAME OF PERSON		2. ADDRESS	
3. OCCUPATION		4. DATE OF BIRTH	
5. SEX		6. RACE	
7. RELIGION		8. EDUCATION	
9. MARITAL STATUS		10. SOCIAL SECURITY NUMBER	
11. EMPLOYER		12. DATE OF ENTRY	
13. REASON FOR ENTRY		14. STATUS	
15. COMMENTS		16. SIGNATURE	
17. DATE		18. OFFICIAL	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
02481		CERTIFICATE OF DEATH	
02473			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>13129 Superior Street</b>	
3. NAME OF DECEASED (Type or print) <b>DONALD R. STOUGH</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Dec 1928</b>
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consultant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harvey C. Stough</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>1/22/46 12/13/49</b>		16. SOCIAL SECURITY NO. <b>162-20-4023</b>	
17. INFORMANT <b>Lillian P. Stough - Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>occlusion of descending branch of aorta</b> DUE TO (c) <b>atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>myocardial ischemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>66</b> , to <b>2/22</b> , 19 <b>67</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>2/20</b> , 19 <b>67</b> , and that death occurred at <b>8:35 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles V. Pate</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles V. Pate</b>		22d. ADDRESS <b>3335 Tennyson St., N.W., Wash., D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brush Creek</b>		23d. LOCATION (City or Town) (County) (State) <b>Erwin, Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b>		25a. REC'D BY REGISTRAR <b>Feb 27 1967</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF NEW YORK

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AMERICAN  
REPUBLICAN  
PARTY  
STATE OF NEW YORK  
LEGISLATIVE  
COMMISSIONERS  
OF THE LAND OFFICE  
TO THE PEOPLE OF THE STATE  
OF NEW YORK  
IN SENATE  
JANUARY 1893

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02482

CERTIFICATE OF DEATH

02474

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN lb <b>40 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		d. STREET ADDRESS <b>4111 Woodbine Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4111 Woodbine Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nevin W. STRAUSBAUGH</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>8,</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1890</b>
9. AGE (In years last birthday) yrs. <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proof-reader-Evening Star Paper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George B. Strausbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Treadway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-2205</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO (b) <b>Carcinomatosis</b> DUE TO (c) <b>Primary site of carcinoma undetermined</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>? 300 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1, 1967</b> to <b>2-8-67</b> that (I) (we) last saw the deceased alive on <b>1-26-1967</b> , and that death occurred at <b>1:30 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>George A. Gray, Jr.</b> M.D.		22b. DATE SIGNED <b>2-8-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE A. GRAY, JR.</b>		22d. ADDRESS <b>4740 Chevy Chase Drive Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-9-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John R. Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02482

02474

RECEIVED BY MAIL

ALL BOOKS ARE RETURNED

NOV 19 1964

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 13, 14 Film G386 3/6/67 mh  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02483

02475

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4m</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>National Institute of Health</u>			d. STREET ADDRESS <u>5201 Conn. Ave -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Boris</u> Middle <u>C</u> Last <u>Swerling</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1967</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>4/9/1920</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>craft</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>unk</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>National Institute of Health</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>9731</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1m</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Inhaled exhaust fumes from car by door in back corner</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:4</u> <u>2/20</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NIH</u>	20f. (City or town) <u>Bethesda</u>	(County) <u>Montgomery</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D.		22. DATE SIGNED <u>2/20/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2/20/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>FEB. 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BATHURST LAWN CEM.</u>	23d. LOCATION (City or Town) <u>TORONTO</u>	(County) <u>CANADA</u>	(State)
24. FUNERAL DIRECTOR <u>B. Conzalez &amp; Sons</u>			25a. REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>		
ADDRESS <u>3501-14 ST. NW</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

07150

1.8250

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02484						02476					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. &amp; HOSP.</u>						d. STREET ADDRESS <u>1003 LOXFORD TERR.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONARD</u> <u>TARNOVE</u>						4. DATE OF DEATH Month Day Year <u>2-9-1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-25-14</u>		9. AGE (In years lost birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linen Supply</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan</u>						14. MOTHER'S MAIDEN NAME <u>Bertha Waggenheim</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>150-07-5726</u>		17. INFORMANT <u>Leonard Goldstein</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary artery heart disease</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City, County, State) <u>2/10/1967</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ohev Shalom-Talmud Torah</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>					
24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons</u>						25a. REC'D BY REGISTRAR <u>3501-14th St. NW, Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>FEB 14 1967</u>											

05436

18338

949-5588

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02485

CERTIFICATE OF DEATH

02477

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
c. LENGTH OF STAY IN Tb <b>36 days</b>		d. STREET ADDRESS <b>6408 14th Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Allen</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1903</b>
9. AGE (In years last birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months <b>15</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Boston, Massachusetts</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Ferdinand Taylor</b>	
14. MOTHER'S MAIDEN NAME <b>Eleanor Allen</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>036-10-0284</b>		17. INFORMANT <b>Alexandria, Virginia</b> <b>Mrs. Margaret May Taylor, 6408 14th St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Colon with widespread metastases</b> DUE TO (b) <b>1538</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital attended the deceased from <b>January 10, 1967</b> to <b>February 15, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 15</b> 19 <b>67</b> , and that death occurred at <b>4:50</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>Feb. 16, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. K. ROEDER, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Cremation</b>	23b. DATE THEREOF <b>2/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington-National- Lee/</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia-Wash.D.C.</b>
24. FUNERAL DIRECTOR <b>Dominic Funeral Home</b> <b>520 South Washington St., Alexandria Va.</b>		25a. REC'D BY REGISTRAR <b>FEB 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08477

STATE OF TEXAS

08482

Name		John	
Address		1000 North Main Street, Houston, Texas	
Occupation		Salesman	
Date of Birth		1910	
Place of Birth		Houston, Texas	
Marital Status		Single	
Education		High School	
Previous Employment		None	
Reason for Leaving		None	
References		None	
Signature		John	
Date		1910	
Witness		None	
Notary Public		None	
County		Houston	
State		Texas	



FOR STATE  
HEALTH DEPT.

02486

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02478

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN IB <u>9 days</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>810 Harrington Road</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond J. Thom, Jr.</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/1947</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond J. Thom, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes active WWII</u>		16. SOCIAL SECURITY NO. <u>579-09-5919</u>	
17. INFORMANT <u>Ardis Miller</u>		Address <u>13237 Clifton Road Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8161 Hemorrhage, intracerebral and sub-dural</u> DUE TO (b) <u>Trauma and deceleration</u> DUE TO (c) <u>Automobile accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>20 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Broncho-pneumonia, bilateral, hypostatic</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran his car head on into truck</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:20 p.m. 2/1 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Wheaton</u> (County) <u>Montgomery</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>2/21/67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or Town) <u>Silver Spring, Maryland</u> (County) (State)
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles George</u>	

03478

03480

1952-1953

x

x

John A. Davis

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02487

02479

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Silver Spring</b> c. LENGTH OF STAY IN 1b <b>20 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>915 Randolph Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Silver Spring</b> d. STREET ADDRESS <b>915 Randolph Rd.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Franklin Gates Thompson</b>		4. DATE OF DEATH <b>Feb. 15 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29 1910</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. House Painting</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Marshall Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Gates</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579 01 4302</b>	
17. INFORMANT <b>Mrs Henry Whalen</b>		Address <b>3515 Decatur St. Kensington Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Pulmonary fibrosis emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>10/1/66</b> , 19..., to <b>2/15/67</b> , 19..., that (I) (we) last saw the deceased alive on <b>2/10/67</b> , 19..., and that death occurred at <b>4 P.M.</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Patrick Jameson</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Patrick Jameson</b> 22b. DATE SIGNED <b>2/17/67</b> 22d. ADDRESS <b>11718 Georgia Ave. Silver Spring.</b>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 18 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		23d. LOCATION (City, town or county) (State) <b>Sunshine Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

12487

12487

Montgomery

Maryland

Montgomery

Rural Silver Spring

20 Years

Rural Silver Spring

912 Randolph Rd.

912 Randolph Rd.

Charles

Franklin Gates Thompson

Feb.

27

White

Male

Nov. 29 1910

56

Painter

Gen. House Painting

Montgomery Co. Md

U.S.A.

James Marshall Thompson

Margaret Gates

3215 Decatur St.  
Washington Md.

279 01 1305 Mrs Henry Whalen

*Delmar County, Delaware*  
*Delmar County, Delaware*

4/10/67

4/10/67

4/10/67

Patrick Jameson

11718

Georgia Ave. Silver Spring

Born Feb. 18 1907 Mt. Carmel

Swainsboro

Md.

Francis H. Barber  
Laytonville, Md.

02488

## CERTIFICATE OF DEATH

02480

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN b <b>14 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>24 E. Montg. Ave. Apt #9</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>PAUL R. TITUS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1967</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/95</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gardner-US Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Joseph Titus</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Haller</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>577-05-9869</b>		17. INFORMANT <b>James Titus-24 E. Montg. Ave., Rockville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>27 days</b> <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>2/16/67</b> , 19 <b>67</b> , to <b>2/23/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/23/67</b> , 19 <b>67</b> , and that death occurred at <b>7A</b> M, from causes and on the date stated above.											
22a. SIGNATURE <b>Henry C. Scruggs</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/23/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs</b>				22d. ADDRESS <b>Cedar Lane, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>					
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b>				ADDRESS <b>Rockville, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

02489

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02481

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN HOSP</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u>		4. DATE OF DEATH <u>2</u> <u>7</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG FAIR</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID COHEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>153-01-5875</u>	
17. INFORMANT <u>ALAN S. TOBIN SON</u>		Address <u>1919-REBANON ST MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to carbon monoxide</u> DUE TO (b) <u>poisoning, smoke inhalation, and</u> DUE TO (c) <u>acute pulmonary edema</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>916.0</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Deceased burned in house fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:43 PM 2-7-1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hyattsville Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>Febr. 7, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NATL MEM PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA.</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25. REC'D BY REGISTRAR <u>4217-9th St NW</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 15 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05181

05183

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02490

CERTIFICATE OF DEATH

02482

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>37 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>10225 Kensington Pkwy.</b>	
3. NAME OF DECEASED (Type or print) <b>Maxine Arlen Tollis</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1924</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Atlantic City, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leslie Arlen</b>		14. MOTHER'S MAIDEN NAME <b>Helen Stoerrhe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>141 16 5458</b>	
17. INFORMANT <b>David P. Tollis Kensington, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastases to lymph nodes, lungs and brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12</b> , 19 <b>67</b> , to <b>Feb. 18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb. 18</b> , 19 <b>67</b> , and that death occurred at <b>11:05 P</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>D.R. Foreman</b>		22b. DATE SIGNED <b>20 FEB 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>D.R. FOREMAN, LT MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-23-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington</b>		23d. LOCATION (City or Town) (County) (State) <b>Fairfax Va.</b>	
24. FUNERAL DIRECTOR <b>R.A. PUMPHREY, 7557 WISCONSIN AVE, BETHESDA, MD.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

05483

05483

OFFICE OF DEATH

Y. Davis

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02491

CERTIFICATE OF DEATH

02483

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		d. STREET ADDRESS <u>901 UNIVERSITY Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>RACHEL M. TROUTMAN</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-90</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US GOV.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>
13. FATHER'S NAME <u>FRANK T. SIMONS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH KX C. AITEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FRANK L. TROUTMAN, SON, 1201 CHAPLIN ST. DC</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Infarction - rt cerebral hemisphere</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>66</u> to <u>4/5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1/5</u> , 19 <u>67</u> , and that death occurred at <u>12:45</u> AM, from causes on and on the date stated above.	
22a. SIGNATURE <u>William Brainin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		22d. ADDRESS <u>6124 Central Ave, Capitol Hill Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES, MARYLAND</u>
24. FUNERAL DIRECTOR <u>WILHELM FUNERAL</u> ADDRESS <u>HOME, 4308 SUITLAND ROAD, SUITLAND, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Feb 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02430

02430

02430

1. NAME		2. ADDRESS		3. CITY		4. STATE		5. ZIP	
6. PHONE		7. OCCUPATION		8. EDUCATION		9. MARITAL STATUS		10. AGE	
11. SEX		12. RACE		13. RELIGION		14. POLITICAL PARTY		15. VOTING RECORD	
16. CREDIT HISTORY		17. EMPLOYMENT HISTORY		18. TRAVEL HISTORY		19. FOREIGN RESIDENCE		20. OTHER INFORMATION	
21. SIGNATURE		22. DATE		23. WITNESS SIGNATURE		24. WITNESS DATE		25. OFFICIAL SIGNATURE	
26. OFFICIAL DATE		27. OFFICIAL TITLE		28. OFFICIAL AGENCY		29. OFFICIAL ADDRESS		30. OFFICIAL CITY	
31. OFFICIAL STATE		32. OFFICIAL ZIP		33. OFFICIAL PHONE		34. OFFICIAL FAX		35. OFFICIAL E-MAIL	
36. OFFICIAL WEBSITE		37. OFFICIAL SOCIAL MEDIA		38. OFFICIAL BLOG		39. OFFICIAL YOUTUBE		40. OFFICIAL TWITTER	
41. OFFICIAL FACEBOOK		42. OFFICIAL LINKEDIN		43. OFFICIAL GITHUB		44. OFFICIAL PINTEREST		45. OFFICIAL INSTAGRAM	
46. OFFICIAL SNAPCHAT		47. OFFICIAL TIKTOK		48. OFFICIAL BEHANCE		49. OFFICIAL DEVIANART		50. OFFICIAL ARTSTORY	
51. OFFICIAL ARTS & CRAFTS		52. OFFICIAL CRAFTS		53. OFFICIAL CRAFTS		54. OFFICIAL CRAFTS		55. OFFICIAL CRAFTS	
56. OFFICIAL CRAFTS		57. OFFICIAL CRAFTS		58. OFFICIAL CRAFTS		59. OFFICIAL CRAFTS		60. OFFICIAL CRAFTS	
61. OFFICIAL CRAFTS		62. OFFICIAL CRAFTS		63. OFFICIAL CRAFTS		64. OFFICIAL CRAFTS		65. OFFICIAL CRAFTS	
66. OFFICIAL CRAFTS		67. OFFICIAL CRAFTS		68. OFFICIAL CRAFTS		69. OFFICIAL CRAFTS		70. OFFICIAL CRAFTS	
71. OFFICIAL CRAFTS		72. OFFICIAL CRAFTS		73. OFFICIAL CRAFTS		74. OFFICIAL CRAFTS		75. OFFICIAL CRAFTS	
76. OFFICIAL CRAFTS		77. OFFICIAL CRAFTS		78. OFFICIAL CRAFTS		79. OFFICIAL CRAFTS		80. OFFICIAL CRAFTS	
81. OFFICIAL CRAFTS		82. OFFICIAL CRAFTS		83. OFFICIAL CRAFTS		84. OFFICIAL CRAFTS		85. OFFICIAL CRAFTS	
86. OFFICIAL CRAFTS		87. OFFICIAL CRAFTS		88. OFFICIAL CRAFTS		89. OFFICIAL CRAFTS		90. OFFICIAL CRAFTS	
91. OFFICIAL CRAFTS		92. OFFICIAL CRAFTS		93. OFFICIAL CRAFTS		94. OFFICIAL CRAFTS		95. OFFICIAL CRAFTS	
96. OFFICIAL CRAFTS		97. OFFICIAL CRAFTS		98. OFFICIAL CRAFTS		99. OFFICIAL CRAFTS		100. OFFICIAL CRAFTS	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G386 3/6/67 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02492

02484

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville.</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Green Castle Rd. Near Rt 29.</u>		d. STREET ADDRESS <u>1117 North Pitt Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Mortimer</u> Last <u>Tuck</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1, 1946</u>
9. AGE (In years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during last 2 weeks or last 12 months) <u>Baggage Clerk</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Air Lines</u>	
13. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>		14. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. FATHER'S NAME <u>Russell V. Tuck Sr.</u>		16. MOTHER'S MAIDEN NAME <u>Evangeline Oliver</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of discharge) <u>Yes</u> <u>1964-1966</u>		18. SOCIAL SECURITY NO. <u>577 62 4500</u>	
19. INFORMANT <u>Russell V. Tuck Sr.</u>		20. ADDRESS <u>7728 Greeley Road Hyattsville, Md.</u>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONTUSION, HEART and Lungs - 8214</u> DUE TO (b) <u>Trauma from Motorcycle Accident.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
23. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Motorcycle went off Highway.</u>	
25. TIME OF INJURY Hour <u>6:07</u> P.M. Month, Day, Year <u>2/25 1967</u>	26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	28. (City or town) (County) (State) <u>Burtonsville Mont. Md.</u>
29. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>2/25/67</u>	
30. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	31. DATE THEREOF <u>2/28/67</u>	32. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	33. LOCATION (City or Town) (County) (State) <u>Colmar Manor, P.G. Md.</u>
34. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Maryland</u>		35. REC'D BY REGISTRAR <u>FEB 27 1967</u>	
36. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		37. REGISTRAR'S SIGNATURE <u></u>	

02403

02403

Greenwood, R. A. (R. A. Green)

Greenwood, R. A. (R. A. Green)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

White, J. (J. White)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
02493					02485					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>					
c. LENGTH OF STAY IN 1b <b>26 days</b>					d. STREET ADDRESS <b>10401 Grosvenor Place</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED					4. DATE OF DEATH					
First Middle Last <b>Ellen Maxine VANSANT</b>					Month Day Year <b>February 21 19 67</b>					
(Type or print)										
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 25, 1921</b>		9. AGE (In years last birthday) yrs. <b>45</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Fort Wayne, Indiana</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>unknown</b>					14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>305-14-5426</b>		17. INFORMANT <b>Rockville</b> Address <b>Md.</b> <b>CDR Victor W. VANSANT, 10401 Grosvner Place</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <b>Pneumonia</b>										
DUE TO (b) <b>Multiple Acute Myelocytic Leukemia</b>										
DUE TO (c) <b>Multiple Acute Myelocytic Leukemia</b>										
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 26</b> , 19 <b>67</b> , to <b>Feb. 21</b> , 19 <b>67</b> , that <del>he</del> (we) last saw the deceased alive on <b>Feb. 21</b> , 19 <b>67</b> , and that death occurred at <b>1235A</b> , from causes and on the date stated above.										
22a. SIGNATURE <b>Ross B. Moquin</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>21 Feb. 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Ross B. Moquin, M. D.</b>					22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b> <b>1331 East Montgomery Ave., Rockville, Md.</b>					25a. REC'D BY REGISTRAR <b>DATE FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

58150

CEAST

02494

## CERTIFICATE OF DEATH

02486

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>3100 Homewood Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>Philip J. Viehmann</b>		4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1896</b>
9. AGE (In years lost birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George A. Viehmann</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Fitzgerald</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>578-09-5028</b>	
17. INFORMANT <b>Wife</b>		Address <b>Mary L. Viehmann Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>150X Pulmonary Embolus</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <b>Concomitant of Esplenus</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> , 19 <b>67</b> , to <b>6 Feb</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>5 Feb</b> , 19 <b>67</b> and the death occurred at <b>4 P</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>George William Ware</b>		22b. DATE SIGNED <b>2/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>George William Ware, M.D.</b>		22d. ADDRESS <b>1835 Egan Pkwy</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-9-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03450

2025



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02495

CERTIFICATE OF DEATH

02487

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>108 Cedar Ave.</b>		d. STREET ADDRESS <b>11 Walker Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Minnie Briggs Walker</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>25th</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 17th 1886</b> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Montg; Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Giddian Briggs</b>		14. MOTHER'S MAIDEN NAME <b>Ida Sparror</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Milton M. Walker.</b>		Address <b>Gaithersburg 108 Cedar Ave. Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>4201</b> (b) <b>Cardio Vascular Hypertensive disease</b> DUE TO <b>5 yrs</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 <b>2-25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/16</b> 19 <b>67</b> , and that death occurred at <b>1:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. Brosch</b>		22b. DATE SIGNED <b>2-25-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Brosch</b>		22d. ADDRESS <b>11 Hutton St. Gaithersburg Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-27-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Gaithersburg Montg Md</b>
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>		25a. REC'D BY REGISTRAR <b>Charles Jones</b>	
ADDRESS <b>Gaithersburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	
DATE <b>FEB 28 1967</b>			

05482

05482

STATEMENT OF DEATH

1901 2 28 37

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

02496

CERTIFICATE OF DEATH

02488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>	
c. LENGTH OF STAY IN lb <u>1 day</u>		d. STREET ADDRESS <u>5448 Varnum St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>M</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>94</u> <u>1/11/44</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quinlan</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Ward</u>		14. MOTHER'S MAIDEN NAME <u>Minna Paul</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		17. INFORMANT Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PULMONARY EDEMA</u> DUE TO (c) <u>ASHD &amp; ATRIAL FIBRILLATION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>24 HOURS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3 FEBRUARY</u> , 19 <u>67</u> , to <u>4 FEBRUARY</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4 FEBRUARY</u> , 19 <u>67</u> , and that death occurred at <u>3<sup>30</sup></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S Caldwell</u> M.D.		22b. DATE SIGNED <u>2-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL</u>		22d. ADDRESS <u>ROCKVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
ADDRESS <u>Mt. Rainier, Maryland</u>		DATE <u>FEB 10 1967</u>	

03430

DEPARTMENT OF STATE

03430



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02497

## CERTIFICATE OF DEATH

02489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Rock Island</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Moline</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>516 Court #5 Springbrook</u>	
3. NAME OF DECEASED (Type or print) First <u>Jona</u> Middle <u>Isabel</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1890</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David H. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Frances C. Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>330-09-1347</u>	
17. INFORMANT <u>Mrs. Opal Sisson</u>		Address <u>Box 726 R. 9. 21 Baltimore, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Tosis</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>67</u> , to <u>2/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>R.P. Benack MD</u>		22b. DATE SIGNED <u>2/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.T. Benack MD</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>	23b. DATE THEREOF <u>Feb 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moline Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Moline, Illinois</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u> ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 6 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02498

## CERTIFICATE OF DEATH

02490

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>9201 Shelton St.</u>	
3. NAME OF DECEASED (Type or print) <u>Hattie</u> First <u>Watts</u> Middle Last		4. DATE OF DEATH <u>2-21</u> Month <u>2</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>gr</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-86</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House mother</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Girls Industrial school</u>	9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House mother</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Girls Industrial school</u>	11. BIRTHPLACE (County & State, or foreign country) <u>KANSAS</u>
13. FATHER'S NAME <u>Charles Thayer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-14-0187</u>	
17. INFORMANT <u>Daughter</u>		Address <u>above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>410X</u> IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Rheumatic Aortic and Mitral Valvulitis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive Heart Disease with coronary arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>(11)</u> (this hospital) attended the deceased from <u>Feb. 20, 1967</u> , to <u>Feb. 20, 1967</u> , that <u>(11)</u> (we) last saw the deceased alive on <u>2-20</u> 19 <u>67</u> , and that death occurred at <u>11:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred S. Norton</u>		22b. DATE SIGNED <u>2/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED S. NORTON</u>		22d. ADDRESS <u>7710 Dwight Drive Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial-transit 2-23-67</u>	<u>2-23-67</u>	<u>Olive Branch Cemetery</u>	<u>Kensington, Kansas</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Feb 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02493				CERTIFICATE OF DEATH				02491			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>VA.</u> b. COUNTY <u>VA.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15810 Bradford Rd. Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nokesville</u>					
c. LENGTH OF STAY IN IB <u>2 mos.</u>						d. STREET ADDRESS <u>93-3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bradford Rest Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST NORMAN Webster</u>						4. DATE OF DEATH Month Day Year <u>Feb. 4 1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-82</u>		9. AGE (In years last birthday) <u>84 yrs.</u>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VA. - Nokesville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>HENRY WEBSTER</u>						14. MOTHER'S MAIDEN NAME <u>Harriett Foulks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>227-14-4290</u>					
17. INFORMANT <u>Record - Bradford Rest Home</u>						Address <u>15810 Bradford Rd. Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Arteriosclerotic Vascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Many years</u> (c) <u>1 Day</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12-8-1966</u> to <u>2-4-67</u> , that (I) (we) last saw the deceased alive on <u>1-22-1967</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Oliver Jackson</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-4-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Oliver Jackson</u>						22d. ADDRESS <u>202 Martin Ln., Rockville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 7, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Manassas, Va. 22110</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Browder</u> ADDRESS <u>Rockville, Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 7 1967</u>		25b. REGISTRAR'S SIGNATURE			

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UNITED STATES DEPARTMENT OF COMMERCE

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Bureau of Commerce" and "Department of Commerce" are faintly visible.]*

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02500

CERTIFICATE OF DEATH

02492

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>				c. LENGTH OF STAY IN 1b --			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u>				d. STREET ADDRESS <u>6208 MEADOW CT.</u>			
3. NAME OF DECEASED (Type or print) <u>BEATRICE CLARK WHARTON</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>JAN 15, 1904</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STATE DEPT.</u>			
13. FATHER'S NAME <u>WILLIAM ATKINSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HITCH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) --				16. SOCIAL SECURITY NO. --			
17. INFORMANT <u>MR. LOWRY N. COE-6208-Meadow Ct.</u>				Address <u>ROCKVILLE, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO <u>4330</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>LONGESTIVE HEART FAILURE</u> DUE TO (c) <u>MYOCARDITIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>LUPUS ERYTHEMATOSIS + RHEUMATOID ARTHRITIS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 15, 1965</u> , to <u>FEB 7, 1967</u> , that (I) (we) lost saw the deceased alive on <u>FEB 6, 1967</u> , and that death occurred at <u>1155A</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Thomas F. O'Connor</u>				22b. DATE SIGNED <u>2/7/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR MD</u>				22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-8-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>FEB 14 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

02493

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, MD</u>		c. LENGTH OF STAY IN 1b <u>8 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Sp. Nursing Home</u>		d. STREET ADDRESS <u>8303 Piney Br. Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE H. WHITING</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov't Emp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	9. AGE (In years last birthday) <u>88</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON-DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>RICHARD T. Whiting</u>		14. MOTHER'S MAIDEN NAME <u>Mary Quigley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 44 4213</u>	
17. INFORMANT <u>Mr. Wm. Whiting</u>		Address <u>4506 Highland Bethesda, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>57</u> , to <u>Feb 20</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Feb 20</u> 19 <u>67</u> , and that death occurred at <u>2:45 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Feb 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. HILL</u>		22d. ADDRESS <u>8641 Colson Rd. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company Washington, DC</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 23 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

03201

CERTIFICATE OF DEATH

03201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02502

CERTIFICATE OF DEATH

02494

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN lb <u>19 hours</u>				d. STREET ADDRESS <u>15907 Sycamore Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lottie Elizabeth Whitmire</u>				4. DATE OF DEATH <u>February 9, 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 13, 1886</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hswt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>McGee</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Rice</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>7600 Carroll Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>coronary thrombosis</u> DUE TO (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/66</u> , 19 <u>66</u> , to <u>2/9/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/8/67</u> , 19 <u>67</u> , and that death occurred at <u>6 A</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>Patrick C. Jameson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Patrick C. Jameson</u>				22d. ADDRESS <u>11718 Georgia Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. Washington, D. C.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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INVESTIGATION OF DEATH

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Mr. Patrick C. Carson  
5-12-1967  
Joseph Davis's sons, Inc. Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02503

CERTIFICATE OF DEATH

02495

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>1 month-20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		<b>15-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				d. STREET ADDRESS <b>309 Ethan Allen Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lillian Estelle Wicker</b>		First Middle Last		4. DATE OF DEATH <b>February 25</b>		19 <b>67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-04</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GPO</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Elisha Wicker</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Adams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-44-8524</b>		17. INFORMANT <b>Patient's chart</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung</b> DUE TO (b) <b>adenocarcinoma of uterus</b> DUE TO (c) <b>174X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 9, 1966</b> , to <b>Feb 25, 1967</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Feb 25</b> , 1967, and that death occurred at <b>1:55 A.M.</b> , from causes on and on the date stated above.							
22a. SIGNATURE <b>Russell B Arnold</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RUSSELL B. ARNOLD</b>				22d. ADDRESS <b>1106 Spring St Silver Spring Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 28, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Signal Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hanover County, Va.</b>	
24. FUNERAL DIRECTOR <b>J. Arthur Walters, 254 Carroll St NW-10C</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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CERTIFICATE OF DEATH

WILLIAM ESTELLE WATKINS

WILLIAM ESTELLE WATKINS

WILLIAM ESTELLE WATKINS

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WILLIAM ESTELLE WATKINS



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02504

## CERTIFICATE OF DEATH

02496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>27 MO.</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNIVERSITY NURSING HOME</u> <u>701 ARCOLA AVE.</u>		d. STREET ADDRESS <u>302 WILLIAMSBURG DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLGA CHRISTINE WIEDMAIER</u>		4. DATE OF DEATH Month Day Year <u>FEB. 28 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23/1979</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>OSLO, NORWAY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MARTIN NILSEN</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINE TOLLERUD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MARTIN A. STRONB</u>		Address <u>Silver Spring, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4201 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Ischemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>10 day</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1950</u> , to <u>Feb 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 28, 1967</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Wardrop, MD</u>		22b. DATE SIGNED <u>2/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. WARDROP MD</u>		22d. ADDRESS <u>808 PERSHING DRIVE SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/6/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co-Silver Spring, MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAR 6 1967</u>	

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be removed. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4230 - 40th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha April Wildman</u>		4. DATE OF DEATH <u>Feb 11 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/80</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR <u>11</u> Months <u>19</u> Days <u>6</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - CIVIL SERVICE U.S. GOV'T.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington - Michigan</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob April</u>		14. MOTHER'S MAIDEN NAME <u>AGATHA FREY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>578-36-2623</u>	
17. INFORMANT <u>Robert A. Wildman - Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1966</u> , to <u>Feb 11 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 10 1967</u> , and that death occurred at <u>5:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W. F. Luckett</u>		22b. DATE SIGNED <u>2-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM. F. Luckett</u>		22d. ADDRESS <u>5000 RENO RD, N.W., WASH., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA.</u>	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, 5130 WIS. AVE., N.W., WASH., D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. G. Judge</u>	

CPASQ

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CERTIFICATE OF DEATH

02498

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, N.W.</u> 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2949 Garfield Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>Washington Biscoe Williams</u>		4. DATE OF DEATH <u>2-19-67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rep. Sch. B Beer Co. (Self Employed)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Williams</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Connor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-5237</u>	
17. INFORMANT <u>Wife - Gladys</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>42</u> to <u>2/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>67</u> , and that death occurred at <u>12:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Leonardo</u>		22b. DATE SIGNED <u>2-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.C. LEONARD</u>		22d. ADDRESS <u>5801-13th ST N.W. WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-21-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		DATE <u>FEB 24 1967</u>	

MEDICAL CERTIFICATION

Cleared by Connor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02507

CERTIFICATE OF DEATH

02499

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN lb <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Springfield</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b> d. STREET ADDRESS <b>8646 Cromwell Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Barbara Alice WILLIS</b> First Middle Last		4. DATE OF DEATH <b>February 21 1967</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 June 1924</b> 9. AGE (In years lost birthday) yrs. <b>42</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Lancaster, Penn.</b>
13. FATHER'S NAME <b>ISIDORE ROSENTHAL</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE MCKINNEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles WILLIS, 8646 Cromwell Dr Springfield, Va.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Lobular Pneumonia</b> DUE TO (b) <b>Severe Asthmatic Bronchitis</b> DUE TO (c) <b>None</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>16 February 1967</b> to <b>21 Feb 1967</b> , that (I) (we) last saw the deceased alive on <b>21 Feb 1967</b> , and that death occurred at <b>0728 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. J. Zimmerman</b>		22b. DATE SIGNED <b>22 Feb 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. J. ZIMMERMAN</b>		22d. ADDRESS <b>Naval Hospital Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Co. Va.</b>
24. FUNERAL DIRECTOR <b>EVERLY WHEATLEY, 1500 W. Braddock Rd. Alexandria, Virginia</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

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INFORMATION TEAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02508

# CERTIFICATE OF DEATH

02500

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland/Indiana</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>155 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River Indianapolis 52-3</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>431 1/2 Mass. Ave.</b> <b>US Naval Air Service</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Melvin</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Apr. 22, 1930</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>	9. AGE (In years last birthday) yrs. <b>36</b> IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harley Hobart Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Melvina Grace Fisher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1948 To 1967</b>		16. SOCIAL SECURITY NO. <b>309 28 5347</b>	
17. INFORMANT <b>MELVINA G GRAVES INDIANAPOLIS, IND.</b>		Address <b>431 1/2 MASS AVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> DUE TO <b>1420</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) Metastatic Adenocarcinoma Parotid</b> DUE TO <b>(c)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>Sept. 15, 1966</b> to <b>Feb. 17, 1967</b> , that (X) (we) last saw the deceased alive on <b>Feb. 17, 1967</b> , and that death occurred at <b>6:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>H. E. Ashworth</b>		22b. DATE SIGNED <b>19 February 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. E. Ashworth, IT MC USN</b>		22d. ADDRESS <b>Naval Hospital Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Fairfax Va.</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers 1400 Chapin St, N.W.</b>		ADDRESS <b>Washington, D.C.</b>	25a. REC'D BY REGISTRAR <b>FEB 23 1967</b>
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

02508

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CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
John Doe		1900-01-01		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		1950-01-01		Heart Disease	
Occupation		Residence		Burial Place	
Teacher		123 Main St		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
1950-01-01		New York City		[Seal]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02503

02501

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7100 Muncaster Mill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>en route to Montgomery Gen'l. Hospital</u>		d. STREET ADDRESS <u>7100 Muncaster Mill Road</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Elsie</u> Last <u>Wilver</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>7</u> Year <u>1967</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <u>April 9, 1898</u>	<b>8. DATE OF BIRTH</b> <u>68</u> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D. C.</u>	
<b>13. FATHER'S NAME</b> <u>William Rice Rogers</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Mahorney</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		<b>17. INFORMANT</b> Address <u>Montgomery General Hospital records</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic - Coronary Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>2-3 yrs.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus.</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b> <u>1948</u> <u>19</u> to <u>67</u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov</u> <u>1966</u> <b>to</b> <u>3-23-67</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1966</u> <b>and that death occurred at</b> <u>3:23 A.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Richard A. Yates</u> M.D.		<b>22b. DATE SIGNED</b> <u>2/7/67</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Richard A. Yates, M.D.</u>		<b>22d. ADDRESS</b> <u>Olney, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>2-10-67</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland, Maryland</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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## CERTIFICATE OF DEATH

02502

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN lb. <u>8 days</u>		d. STREET ADDRESS <u>4311 Warner Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>FRANK</u> Middle <u>Wininger</u> Last		4. DATE OF DEATH <u>2-9</u> Month <u>2</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) yrs. <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Life Way Store</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Portsmouth VA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Wininger</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Chynon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW2 Navy</u>	
16. SOCIAL SECURITY NO. <u>577 05 1991</u>		17. INFORMANT <u>Vera E. Buegames</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic broncho-pneumonia</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Advanced coronary arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema, postural, large lung type.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/2</u> , 1967, to <u>2/9</u> , 1967, that (I) (we) lost saw the deceased alive on <u>2/9</u> , 1967, and that death occurred at <u>2:24</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u>		22b. DATE SIGNED <u>2/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Pollen MD</u>		22d. ADDRESS <u>10400 CONNECTICUT AVE, KENSINGTON, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05250

05250

05250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c Film #G386 3/20/67

02511

CERTIFICATE OF DEATH

02503

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>4 mos - 5 da</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patientships / Nursing Home / Polesville Md</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>P.</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 6 - 1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES E. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Susie White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-187632</u>	
17. INFORMANT Address <u>Mrs. Wm. Syles Barnesville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <u></u> (c) DUE TO <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-21, 1966</u> , to <u>2-19, 1967</u> , that (I) (we) last saw the deceased alive on <u>2-14, 1967</u> , and that death occurred on <u>2-19-67</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D. F. Sengstack M.D.</u>		22b. DATE SIGNED <u>2-19-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City or Town) (County) (State) <u>Bearsville Montg. Md</u>	
24. FUNERAL DIRECTOR <u>William C Hiltz, Barnesville, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
MAIL ROOM

FOR STATE  
HEALTH DEPT.

02512

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02504

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12525 Glenn Mill Rd.</u>		d. STREET ADDRESS <u>12525 Glenn Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Arnold W. WOODRUM</u>		4. DATE OF DEATH Month <u>Feb</u> - Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1900</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaping</u>	
11. BIRTHPLACE (State or foreign country) <u>Charleston, West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>315-16-2940</u>	
17. INFORMANT <u>Airred Barnes step son</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe Coronary arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>  <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>2/15/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		7936 Old Georgetown Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/17/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Germantown Ch. Cem</u> <u>Germantown, Montg</u> <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>1331 Rock Pike, Rockville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 20 1967</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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02513

## CERTIFICATE OF DEATH

02505

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				d. STREET ADDRESS <u>10206 Tenbrook Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>NONE</u> Last <u>Yelnick</u>				4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-92</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam Goodman</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> 6301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PERITONITIS - RUPTURED PYOMETRIUM 21 HOURS</u> DUE TO (c) <u>PYOMETRITIS</u> 5 MONTHS							INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> , 19 <u>66</u> , to <u>FEBRUARY</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>FEBRUARY 5</u> 19 <u>67</u> , and that death occurred at <u>9P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>FEBRUARY 5 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>				22d. ADDRESS <u>7733 AKASKA AVENUE NW WASHINGTON DC 20012</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DEO CASH CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE, MD</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> ADDRESS <u>421 K St NW</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, if any event, within 72 hours after death.

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02514

CERTIFICATE OF DEATH

02506

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>473</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmore San</u>				d. STREET ADDRESS <u>1717-18TH ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>MARY Elizabeth Young</u>				4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/1875</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Young</u>				14. MOTHER'S MAIDEN NAME <u>Annie C Forester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>JOHN R. YOUNG, PO Box 36, EXTON, PA.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>1530</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>carcinoma of cecum</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>FEB 25</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>FEB 25</u> 19 <u>67</u> , and that death occurred at <u>4:55 PM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>E. F. Quayle</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. F. Quayle M.D.</u>		22d. ADDRESS <u>1822 Baltimore St NW Washington D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, 5130 WIS. AVE. NW, WASH., D.C.</u>				25a. REC'D BY REGISTRAR OATE <u>MAR 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

05206

CERTIFICATE OF DEATH

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02515 CERTIFICATE OF DEATH 02507

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) s. STATE <i>Maryland</i> COUNTY <i>Frederick</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>Rt # 2</i>	
3. NAME OF DECEASED (Type or print) First <i>Wilbur</i> Middle <i>E.</i> Last <i>Young</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>13</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/21/04</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>13</i>	
IF UNDER 24 HRS. Hours <i>13</i> Min. <i>00</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brickman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B + O Railroad</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland (Carroll Co)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles C. Young</i>		14. MOTHER'S MAIDEN NAME <i>Daisy K. Garver</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <i>214-10-2361</i>	
17. INFORMANT <i>Mrs. Mary Z. Young</i>		Address <i>Same As #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Obstructive Pulmonary Emphysema</i> 5271 DUE TO (b) <i>10 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Chronic Lymphocytic Leukemia</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/1</i> , 1964, to <i>2/13/1967</i> , that (I) (we) last saw the deceased alive on <i>2/13/1967</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert C. Macon</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. Macon, M.D.</i>		22d. ADDRESS <i>809 Viers Mill Road Rockville, Maryland 20851</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/16/1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ijamesville Methodist</i>		23d. LOCATION (City, town or county) (State) <i>Frederick Co., Md.</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz</i> ADDRESS <i>Box 241 Sykesville, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>FEB 16 1967</i>			

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609 Viera Hill Road  
Knoxville, Tennessee 37921

Robert C. Faxon, Jr.

March 10, 1967

C. H. Faxon, Jr., Knoxville, Tenn.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

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CERTIFICATE OF DEATH

02508

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>8915 2nd Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>S.</u> Last <u>Zubalake</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 17</u> <u>XXXXXX</u> 1900	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Stappas</u>				14. MOTHER'S MAIDEN NAME <u>Helen Stasopoulos</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Michael Zubalake</u> Address <u>1401 Sheridan Street, N.W. Washington, D. C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lt. Cerebral Infarction</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute diffuse peritonitis due to ruptured duodenal ulcer</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notule of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-23, 1967</u> , to <u>2-26, 1967</u> that (I) (we) last saw the deceased alive on <u>2-25, 1967</u> , and that death occurred at <u>9:15 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>JASON GEIGER, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>				22d. ADDRESS <u>800 PERSHING DRIVE SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter, 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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A large, faint, and mostly illegible form or document, possibly a ledger or record book, occupying the majority of the page. It features horizontal lines and some faint text, but the content is too faded to be transcribed accurately.

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